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BIRTH CONTROL, CULTURE AND THE POOR.

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EVIDENCE FROM STUDIES INDICATE THAT THE POOR DESIRE TO CONTROL THEIR FAMILY SIZE AND PREFER TO USE BIRTH CONTROL DEVICES (PILLS OR INTERUTERINE DEVICES) WHICH ARE NOT COITUS-CONNECTED AND ANTITHETICAL TO THEIR SEXUAL ATTITUDES AND TRADITIONS. CONTRARY TO THE BELIEF THAT THE POOR ARE LESS LIKELY TO UTILIZE EXISTING HEALTH FACILITIES OR TO TAKE PART IN PREVENTIVE HEALTH PROGRAMS, SEVERAL STUDIES HAVE SHOWN THAT WITH THE AVAILABILITY OF BOTH BIRTH CONTROL FACILITIES AND COITUS-INDEPENDENT DEVICES LOWER SOCIOECONOMIC GROUPS INCREASINGLY USE THESE SERVICES. AND, ALTHOUGH THE POPULATION IN SOME OF THESE STUDIES WERE VOLUNTEERS,--THE MOST RECEPTIVE INDIVIDUALS--THERE WAS A "DIFFUSION" EFFECT BEYOND THE ORIGINAL VOLUNTEER SAMPLE. OTHER STUDIES HAVE INDICATED THAT THE USE OF INDIGENOUS NONPROFESSIONALS TO SPREAD INFORMATION AND STIMULATE INTEREST IN THE SERVICE IS A KEY FACTOR IN SUCCESSFUL PROGRAMS. ANOTHER IMPORTANT FACTOR IS THE AVAILABILITY OF BIRTH CONTROL SERVICES IN CONVENIENT LOCATIONS AND AT CONVENIENT TIMES FOR THE POOR. (JL)

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BIRTH CONTROL, CULTURE AND THE POOR

by Catherine Kohler Riessman
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For the first time in the United States, religious and related political pressures are relaxing in the area of birth control and it is now being explored as a matter of public policy.

In terms of the sociology of knowledge it is interesting to note that the current trend is toward increasing birth control services for every branch of the society, not only the middle class. The extension of this health service to the poor on a massive scale is being seriously pondered on a national level. Economically, large families are no longer beneficial to the country or the family. Child labor laws and the industrial age have made obsolete the usefulness of offspring as members of the labor force. The industrialization of agriculture, similarly, removes the need of child labor, historically used on the small family farm. Unemployment among youth is at an all time high, many times greater than the proportional rate among the adult categories.

Thus it might be hypothesized that the new economic conditions, making it no longer functional to have large families, have given rise to increased research into and concrete plans for implementation of birth control services, particularly in the population group most burdened by many children - the poor. In addition to the economic factors reinforcing this change in emphasis, we now have the physical technologies to do the job effectively. The oral contraceptives and the interuterine devices (IUD) have made the question of birth control largely a social one. Medically, the techniques are highly developed and nearly 100% effective. Perhaps the rapid development of these techniques is not unrelated to the changing economic conditions.

Moreover, the anti-poverty program, although hesitantly, is venturing into this area, and has funded a number of programs. With the addition of Medicare, the opportunity for the delivery of the necessary services to the poor on a massive scale is within our grasp for the first time.[1] Can we simply make the techniques of contraception available to this group, as they have been to the middle class? Is it enough to provide the service or must we plan a program specifically tailored to this population, taking into consideration the attitudes and cultural patterns likely to be encountered?

First and foremost, what is the attitude of the low income family toward the area of birth control? Are we likely to encounter deep "cultural" resistance to the idea of limiting family size on religious or value grounds? A study conducted in 1955, using a national sample of 2,713 white married women in child bearing years, shows that women of all classes want to limit their families[2]. Employing the same data Lee Rainwater showed that young women of all classes appear to want the same number of children (2 - 4).[3] The goal, then, appears to remain constant regardless of class. The actual births and the expectation, however, vary with class. "The lower the status (as measured most effectively in this study by the wife's education), the more children the respondents have, and the more they expect."[4] Predictably, the lower the status of the woman, the more children expected; the women with only a grammar school education showed the higher fertility pattern.*

*An investigation of the family size preferences of non-white parents seems to show that non-white wives want fewer children than the white wives in the sample - the average number desired by the non-white sample was 2.9 as against 3.3 by the white wives.[5] Other studies where comparisons of racial groups are made seem also to indicate that Negro respondents consistently expressed the wish to have fewer additional children than the white respondents.[6]

Coitus-Connected Methods of Birth Control

Perhaps the significance of cultural factors can best be understood in relation to low-income attitudes toward the traditional coitus-connected (e.g. condom) methods of birth control. In order to comprehend this issue, it is necessary to examine the attitudes of the poor toward sexual behavior.

Kinsey has documented that lower-income people prefer intercourse in the dark, with their clothes on.[7] Nakedness, both due to crowded living conditions and greater inhibition, is frowned upon. Masturbation is negatively regarded in low-income culture, and apparently practiced less. Fore-play occurs less, also, Kinsey says.

Moreover, low-income people do not talk about sex in the intellectualized, "open" fashion common in middle class families. The organized group meetings sponsored by Planned Parenthood might be somewhat alien to low-income people. Here, a leader typically describes to a mixed audience of men and women the various techniques in a frank, straightforward manner, and discussion follows. From what we know of low-income traditions, this would seem to be an atypical experience. Is it possible in the light of this population's sexual attitudes to have group instruction in mixed groups, or must this be done more in a one-to-one and sex-segregated fashion?

In light of the apparently negative attitude toward masturbation among low-income individuals, a technique such as the diaphram which involves touching of the organs might be resisted. This device, in addition, requires a privacy not always available in low-income homes.

The diaphragm also requires a planning of the evening's sexuality, as it were. The diaphragm and the condom may interfere both physically and psychologically with the direct, "natural," motion of the act.* Middle class people may also object to these mechanical contraceptive devices for this reason. However, they have coping mechanisms, or styles, which allow for these rituals. In addition, they can even utilize these contraceptive procedures as part of the fore-play, as has been suggested by birth control expert Dr. Alan Guttmacher:

> One objection (to the use of the condom) is that love play must be interrupted to put the condom on, but imaginative couples have found this to present no difficulties; they usually make this part of the pleasurable preparations for intercourse with the wife making the placement as a signal that she is ready.[8]

However, this is sexual advice which would probably fall on extremely deaf ears among the low-income population where fore-play is typically not an integral part of the sexual act. Guttmacher currently recognizes the inapplicability of this kind of approach to the low-income group. Referring to the low utilization of Planned Parenthood clinics by the poor, he states:

> The failure of these clinics to attract and help a substantial portion of the population can be accounted for, in the light of recent experiences, by the fact that the contraceptive methods they generally offer are ill-suited to the life circumstances of most poor people...Often they (the women) lack both the privacy and the knowledge required to employ the most effective vaginal methods of contraception; some, for example, unaware of the existence of the cervix, are afraid the diaphragm will be 'lost inside.' For their part, the men are often highly insistent on their 'rights' to coitus, and

*This is not to imply that low-income sexuality is characterized by great freedom and spontaneity. As a matter of fact, as Rainwater et al note in Workingman's Wife, it is frequently quite inhibited and laden with traditional superstitious attitudes.

> impatient with any delay or physical obstruction. Thus, contraceptive techniques that coincide with the very act of coitus...may become extremely problematic...Meanwhile, abortion, a 'coitus-independent' method of birth regulation, commonly flourishes despite the health hazards and legal risks when it is performed clandestinely.[9]

The elaborate monthly records, as well as the daily temperature taking required of the "rhythm method," are much more consistent with the orientation of the middle class person. In low-income homes, with the many pressures, such a technique would be less congenial. In addition, limited education might be expected to make the keeping of these records more difficult.

The oral contraceptive method does meet the cultural needs on the other hand, in that it is, to use Guttmacher's phrase, completely coitus-independent. Also, it is appropriate in other respects. "Since it does not involve the genitals physically or psychologically, it can be talked about freely by these women who, contrary to stereotypes, are often prudish and embarrased to acknowledge their own sexuality, much less to accept and recommend a contraceptive."[10]

The IUD, or any method of permanent contraception, would appear to have the least problems. One of its advantages is that it does not require the planning of the evening's sexuality; it is completely coitus-independent.*

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*On the other hand, low-income people may have disturbing attitudes about a foreign body which is constantly in them. With the less educated, particularly, the mechanics regarding where the device is located and what it does to prevent conception are mysterious. The device is a real magnet for superstition. With more educated persons, the behavior would probably be organized more readily around the new knowledge; education would enable them to understand the process and define it accordingly. The low-income person might be more likely to respond negatively to the strange shape of the coil or other intrauterine device, and be suspicious about its presence in the body. In spite of their superstitions, however, the extreme effectiveness and ease of this method does provoke a response among this group. A little advertised contraception clinic at Sloane Hospital for Women (Columbia University-Presbyterian Medical Center) has been widely utilized by medically indigent women coming for maternity services; in 1963, almost one third of the women who delivered there chose the IUD.[11]

optimistic about the future, and feels that his efforts will bear little fruit."[17] Rainwater sees this cultural trait as the reason behind the inconsistent and ineffective family planning patterns of the poor.

> They (the poor) tend to regard thought and planning as painful activities to be engaged in only under the pressure of great necessity. Even then, they are not optimistic, since they often feel that the best they can do will not be sufficient to overcome adversity - one may be spared unpleasantness by good fortune, one may be 'lucky,' but one cannot be personally successful against difficulty. Such a world view and way of thinking about oneself in the world are not conducive to effective planning. Indeed, they tend to discourage planning and the hope it implies, lest one court disappointment.[18]

In its most extreme form, this thesis of cultural deprivation and its effect on the utilization of health services states that:

> The effective control of fertility requires individual initiative and sustained effort. People who do not really believe that it is possible for them to improve conditions of life for themselves or their children will not undertake a radically new venture or put forth the sustained effort required for success in this undertaking. Where hope is weak, contraception will be absent or ineffective.[19]

But perhaps the thesis of cultural resistance to contraception on the part of the poor was after the fact. Because our public policy was so confused and because services, where available, were fragmented, inconveniently located, inhumanely delivered, and bureaucratically organized, the lack of adequate family planning among the poor was incorrectly seen as reflecting an inability to make use of modern health practices. Because the middle class had little difficulty in limiting their families, we tended to view the problem as culture based, overlooking the greater availability of services and information to this stratum. With the lack of services and educational programs among the

poor regarding the proper use of contraceptive measures, there arose a cycle of skepticism and contraceptive failures, which Rainwater documents so well.. "This 'chain reaction' of failure with conventional techniques may have been a major cause of the traditional lagging interest of many impoverished families."[20] With the improved technology provided by coitus-independent methods (the pill and the IUD) and the beginnings of truly available and accessible services for these groups, the picture changes.

It is becoming increasingly clear that the availability of birth control facilities (clinics, etc.) within the lower socio-economic groups rapidly increases utilization of these services. Several studies have shown that with availability of coitus-independent devices there is continued high utilization of the services. A pilot project in Mecklenburg County, North Carolina begun in 1960 used 264 women volunteers (married, previously married and single parous women) who were Public Welfare clients, and made oral contraceptives available to them. (Ninety percent were Negro, ten percent were white. The mean age was 29, mean grade in high school completed was 9, mean number of children had was 4.8. Of the women working, 89% held unskilled positions, largely as domestics. The majority lives in over-crowded, depressed area housing.)[21] After two years, 223 of these individuals were still active in the program. But perhaps more significant, other women in the county virtually began "knocking the doors down to be referred to the 'pill clinic.'"[22]

It might be added that the response to this service was a great surprise to the officials and professionals involved; the welfare

staff, doctors, nurses, social workers, felt that these economically and socially deprived women "would not be able to follow the regimen necessary to make successful use of the pills."[23] The Mecklenburg study is especially significant in this context, for these patients were using the oral contraceptive, a method perhaps requiring the utmost planning and systematic organization of any of the available methods (one pill a day for 20 successive days).

The Chicago Planned Parenthood conducted a study involving more than 14,000 patients using oral contraceptives: 83% of the patients were non-white, slightly less than half had not completed high school, and one out of six were welfare recipients. It was found that between 70 and 83% continued to take the pills in the required manner for thirty months after they came to the clinic.[24] "This is an astonishingly high retention rate for any procedure requiring continuous self-administration of medication and says something about the readiness of the poor to respond to well-conceived, energetically-delivered voluntary programs employing coitus-independent methods."[25]

It is important to note here, however, that these studies were attempting to reach a selective sample of the poor: the women were volunteers in both the Mecklenburg and the Chicago projects. These, then, were perhaps the most receptive elements of the poor. Rainwater's thesis may still be valid for the non-volunteers in the low-income group: the "sporadic or careless users."[26] The "sporadic users" are composed of couples "with some desire to limit their families but who for a variety of reasons are unable to practice contraception effectively even though they may have considerable knowledge about various methods."[27] But even reaching a small and self-selected percentage of

the poor resulted in a diffusion effect, as it were. In the Mecklenburg study, hundreds of other women, hearing of the service, asked to become part of the program. The availability of the services, therefore, in a comprehensive program, results in the spread of utilization beyond the original volunteer sample.

Writing about the high response to the new programs such as Mecklenburg, Chicago, etc., Hill and Jaffee succinctly capture the differential character of these programs:

> The most successful demonstration projects have, to one degree or another, been considerably different from the kind of medical care which impoverished Negroes normally receive. Instead of compelling patients to sit for hours on end in dingy waiting rooms, appointments are often scheduled (as in private practice) and efforts are made to offer a bright and cheerful atmosphere. Many clinics are located in the heart of impoverished neighborhoods, not halfway across town, and sessions may be scheduled at night and other unusual times to fit patients' needs. Staff members are urged to refrain from imposing their attitudes and values upon patients and nonprofessional workers have been employed to interpret to potential patients how family planning can help them to realize their desires about family size. Baby sitting services are sometimes provided. Fees are adjusted to what the patient can afford. And perhaps most significant, clinics are not segregated by color.[28]

The Significance of the Indigenous Nonprofessional

Rainwater observes that a highly significant new development in the field of family planning among the poor is the use of indigenous nonprofessionals or unemployed neighborhood residents.[29] Here, a cultural approach to the problem is built in, as it were, by having the dispensers of the information be persons from a similar socio-economic background as the recipients, who can communicate in the appropriate cultural idiom. The New York Times recently reported a highly successful

experiment conducted by Bogue and Palmore in the rural South (13 Black Belt counties in southern Alabama, heavily populated by rural Negroes and 8 Appalachian Mountain counties of eastern Kentucky inhabited largely by rural whites) using all the modern contraceptive techniques on a population which many feel is one of the most difficult to reach. "Success apparently depends on a variety of factors. However, one key seems to be the use of local residents, instead of polished, professional outsiders, to spread information by word of mouth...The experimenters have hired a 'family planning educator' in each Black Belt county. The educator is a Negro woman who is widely known, liked and respected in the community, a person able to talk informally with the women visiting the health clinics."[30]

The Planned Parenthood Federation is also utilizing nonprofessional workers in an action-research project in New York City, which uses community centers as its base. The medical team comes into the neighborhood each week by station wagon. "In three of the centers, nonprofessional 'neighborhood workers' are attempting to stimulate interest in the service by organizing 'coffee sips' where family planning is discussed in informal groups."[31] It is unlikely that these workers would present the information in the more clinically antiseptic manner often employed by the professional staff, which encountered resistance on the part of the local residents.

Bringing these services into the neighborhoods of the poor, into store-fronts staffed by nonprofessionals, could constitute a breakthrough. With this approach we are bypassing a cultural analysis, or more accurately, we are incorporating the culture via the nonprofessionals who

function as a link with the poor. With the perfected birth control technology which uses methods less likely to encounter resistance on cultural grounds from the poor, the maximum use of birth control facilities might be forthcoming.

Conclusion

The evidence indicates that low-income people desire to control the size of their families. Their failure to do so in the past was probably related to the lack of available birth control services and to the fact that the only techniques available were coitus-connected. These techniques appear to be antithetical to the sexual attitudes and traditions of the poor.

With the advent of coitus-independent measures, and the effort to make them available to the poor in a humane, well-organized, neighborhood-based fashion, utilization by low-income people is changing dramatically. The culture of poverty thesis which attributes non-use of birth control information by the poor to apathy, a lack of planning, and a non-futuristic orientation, seems to be highly doubtful in light of the new evidence.

> Family planning is not a panacea for all the problems of poverty and dependence, nor is it a substitute for massive social programs to enable (the) impoverished...to obtain jobs, increase income levels, enlarge educational opportunities and otherwise improve their living conditions. But the reduction of poverty and dependency will not be slowed significantly, no matter how comprehensive these programs, unless the poor, white and nonwhite, are also able to have only the number of children they want. In the spectrum of urgently needed programs, family planning is one which is achievable relatively quickly and easily: With modern methods, we have sufficient knowledge and technology; it is a relatively simple and inexpensive aspect of medical care; the number of patients to be served is quite limited; and most important, the poor have shown considerable readiness of response to this service. It is not necessary to remould basic attitudes or develop new aspirations among (the) impoverished..., but to provide the means of realizing aspirations they already have.[32]

Footnotes

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